MRMIP Enrollment Unit
(800) 289-6574

California Major Risk Medical Insurance Program

Enrollment Application

Instructions:

Thank you for applying with California Major Risk Medical Insurance Program. Please follow these instructions to allow us to better process your application.

- Read the brochure to learn about eligibility and to choose your health plan before completing this application.
- You, the applicant/parent/legal guardian must complete this application. You are solely responsible for its accuracy and completeness.
- All questions must be answered in full. **The entire application may be returned to you if you do not provide all necessary information (including the required supporting documentation, signatures, and payments). This may result in a delay in processing.**
- This application must be received by MRMIP within 30 days from the signature date.
- Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy being rescinded.

Attach check to page 30 where indicated.
Please submit one month's subscriber contribution for your chosen health plan.
Regardless of which plan you choose, **make your check payable to California Major Risk Medical Insurance Program.**
If your application is approved, your payment will be forwarded to the health plan you have selected.
Submit check, application and all necessary documentation to:

California Major Risk
Medical Insurance Program
P.O. Box 9044
Oxnard, CA 93031-9044

INSURANCE AGENT: If you assisted your client in completing this application, please complete this section. Complete all boxes – this will not be paid unless complete. Information missing cannot be submitted at a later date. (Please see note to Agents on page 3 of the brochure.)

Agent Name			CA Agent/Broker License No.	Tax I.D. No:/Soc. Sec. No.
Street Address			I understand that no Agent payment will be made unless and until this applicant is enrolled in the Program.	
City	State	Zip		
Phone No.	FAX No: (if available)		Signature	

1. Check One:

☐ New Enrollment ☐ Add Dependents

2. Choice of Health Plan:

(Remember : Regardless of your choice of health plan, make check payable to California Major Risk Medical Insurance Program.)

Health Plan Name	**Name of Primary Care Physician (for Blue Shield HMO only)**

3. Applicant Information: Applicant must complete this section.

(If parent or legal guardian is completing this application for the applicant, please mark this box. ☐)

Last Name Applicant	First Name	M.I.	Social Security Number	Age	Birthdate Mo Day Yr	**10** ☐ Male **20** ☐ Female

Check One 1 ☐ Single 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Home Phone ( )	County

Street Address (must be completed; P.O. Box not acceptable)	Suite or Unit #	City	State	Zip

Billing Name, if different			

Billing Street Address	City	State	Zip

Employer	Occupation	Business Phone ( )

Employer Street Address	City	State	Zip

4. Race/Ethnicity (Optional): Check box which best applies.

10 ☐ Aleut
11 ☐ American Indian, Native American
12 ☐ Black/African American
13 ☐ Eskimo
14 ☐ White

Hispanic
21 ☐ Cuban
22 ☐ Mexican, Mexican-American, Chicano
23 ☐ Puerto Rican
92 ☐ Other; please specify:

Asian
41 ☐ Asian Indian
42 ☐ Cambodian
43 ☐ Chinese
44 ☐ Japanese
45 ☐ Korean
46 ☐ Laotian
47 ☐ Vietnamese
94 ☐ Other; please specify:

Pacific Islander
61 ☐ Filipino
62 ☐ Guamanian
63 ☐ Samoan

Other not listed; please specify:
99 ☐

STAPLE CHECK HERE
payable to California Major Risk Medical Insurance Program

5. Family Information: List all additional family members to be enrolled.

	Last Name	First Name		M.I.	Social Security Number	Age	Birthdate Mo Day Yr
30 ☐ Husband **40** ☐ Wife							
50 ☐ Son **70** ☐ Daughter			Marital Status ☐ S ☐ M				
51 ☐ Son **71** ☐ Daughter			Marital Status ☐ S ☐ M				
52 ☐ Son **72** ☐ Daughter			Marital Status ☐ S ☐ M				
53 ☐ Son **73** ☐ Daughter			Marital Status ☐ S ☐ M				
54 ☐ Son **74** ☐ Daughter			Marital Status ☐ S ☐ M				

Is any dependent child over 23 years of age? Yes ☐ No ☐

If yes, send with this application doctors records showing that the dependent child cannot work for a living because of a physical or mental disability which existed before becoming 23 years old.

Is this dependent child covered by Medicare? Yes ☐ No ☐

6. Program Eligibility: To be eligible for the program you must answer "yes" to one of the first five questions. Provide a copy of any letter or formal written communication from a health plan documenting all "yes" answers.

	Yes	No	Enroller Use Only
1. Within the past 12 months, have you been denied individual health insurance?	☐	☐	
2. Within the past 12 months, have you been involuntarily terminated from health insurance coverage for reasons other than fraud or non-payment of premium?	☐	☐	
3. Within the past 12 months, have you been offered an individual premium higher than the rate for the first choice health plan listed on this application?	☐	☐	
4. Within the past 12 months, have you been denied health insurance as a member of a group of one?	☐	☐	
5. Are you currently ineligible, but anticipate becoming eligible, and want to apply for a deferred enrollment? (See Section 8B.)	☐	☐	
6. Have you and your dependent(s), if any, met the requirements to waive all or part of the exclusion/waiting period? (See page 4 under "How You May Waive All or Part of the Exclusion/Waiting Period.")	☐	☐	
7. Within the past 12 months, were you covered in a similar high risk pool sponsored by another state before becoming a California resident?	☐	☐	

7. Declarations: Please read each of the following statements carefully and initial each statement. Any untrue or inaccurate responses may be reason for loss of enrollment or application of other sanctions.

	Initials
1. I declare that no individual listed on this application is eligible for **both** Part A (hospital) and Part B (professional) of Medicare. If you **are** eligible solely because of end-stage renal disease, leave blank and provide proof. (Medicare is a federal program that provides health services to older Americans and disabled persons.)	
2. I declare that all individuals listed on this application are residents of the state of California.	
3. I declare that I am not currently eligible to purchase any health insurance for continuation of benefits from my employer under the provisions of 29 U.S. Code 1161 (COBRA), or under the provisions of Insurance Code Sections 10128.50 and Health and Safety Code Sections 156.20 (Cal-COBRA). These are the laws which allow people to buy into their employer's health insurance for at least 18 months after they leave their employer. (If you **are** currently on COBRA, leave blank and read 8B below.)	
4. I declare that all individuals listed on this application will abide by the rules of participation, the utilization review process and the dispute resolution process of the participating health plan in which the individual is enrolled. A dispute resolution process may include binding arbitration rather than a court trial to resolve any claim, including a claim for malpractice, asserted by me, my enrolled dependents, heirs, personal representatives, or someone with a relationship to us, against the participating health plan, or against the employees, partners, or agents, of the participating health plan.	
5. I declare that I have reviewed the benefits offered by the MRMIP and the contribution rate.	
6. I declare that no individual listed on this application was excluded from group health coverage solely for the purpose of being made eligible for the MRMIP.	
7. I declare that I understand and will follow the rules and regulations of the MRMIP. I understand that negotiating a subscriber contribution check shall not constitute acceptance on the part of the MRMIP, or any of its subcontractors, if the application is not approved or if the member has already been disenrolled for nonpayment of subscriber contribution, fails to meet program eligibility requirements, commits program fraud, or because the dependent ceases to be a dependent, upon request by the member, or for any other reason.	

8. Effective Date:

Enroller Use Only

A. If this application is approved, the effective date of coverage will be determined according to applicable law and regulation and you will be informed in writing of the date. Do not drop any current coverage until you hear from us.

B. If you are not now eligible, but anticipate eligibility, you may apply for a deferred enrollment. To do so you must include acceptable documentation (e.g., a letter from an insurance company or employer indicating coverage termination). The documentation must be specific as to the date of termination of current coverage

9. Authorization and Conditions of Enrollment

Required by the Confidentiality of Medical Information Act of 1/1/80, Sect 56 et.seq of the California Civil Code for all applicants of 18 years and over. I authorize any insurance company, physician, hospital, clinic or health care provider to give Major Risk Medical Insurance Program Administrator any and all records pertaining to any medical history, services or treatment provided to anyone listed on this application for purpose of review, investigation or evaluation. This authorization becomes immediately effective and shall remain in effect as long as Administrator requires. A photocopy of this Authorization is as valid as the original.

Privacy Notification
The Information Practices Act of 1977 and the Federal Privacy Act require this Program to provide the following to individuals who are asked by the Major Risk Medical Insurance Program (established by Part 6.5 of Division 2 of the Insurance Code) to supply information: The principal purpose for requesting personal and medical information is for subscriber identification and program administration. Program regulations (Chapter 5.5 of Title 10 of the California Code of Regulations, Sections 2698.100 et.seq.) require every individual to furnish appropriate information for application to the Major Risk Medical Insurance Program. Failure to furnish this information may result in the return of the application as incomplete. The following information on the application is voluntary: social security number, race/ethnicity information and health history.

Personal information provided on this form will not be furnished to any other governmental agency.

An individual has a right of access to records containing his/her personal information that are maintained by the Major Risk Medical Insurance Program. The official responsible for maintaining the information is: Deputy Director, Eligibility and Enrollment, Managed Risk Medical Insurance Board, 1000 G Street, Suite 450, Sacramento, CA 95814. The Board may charge a small fee to cover the cost of duplicating this information.

I understand that this is a state program and my rights and obligations under it will be determined under Part 6.5 Division 2 of the California Insurance Code and at the regulation of Title 10, Chapter 5.5.

If you enroll in certain plans you agree to have certain claims (which may include medical malpractice claims) decided by neutral binding arbitration. Members give up their right to a jury or court trial. Page 6 has information about each plan and the arbitration requirements. You may call the plan you choose to find out more.

I understand that this contract may have waiting periods for pre-existing conditions.

I, the applicant, certify that the information provided on this application is true and correct.

X		**X**	
Signature of Applicant/Parent or Legal Guardian Required	Date	Signature of Applicant's Spouse Required (If listed on this application)	Date
X		**X**	
Signature of Applicant's Dependent Age 18 or over Required (If listed on this application)	Date	Signature of Applicant's Dependent Age 18 or over Required (If listed on this application)	Date

After filling out the application, signing and securing all necessary documentation, submit with a check for one month's subscriber contribution for your chosen health plan. **Make your check payable to California Major Risk Medical Insurance Program** and mail to:

California Major Risk
Medical Insurance Program
P.O. Box 9044
Oxnard, CA 93031-9044